ANNUAL REPORT OF CLAIMS INVENTORY

PART 2

For each individual underwriting company in an insurance group or client of a third-party administrator (whether a self-insured employer or an insurer), whose claims are administered at the adjusting location, complete the following:

COMPANY NAME	**CHECK ONE:**
STREET ADDRESS	_____ Insurance Company
CITY/STATE/ZIP	_____ Self-insured employer (private or public including joint powers authority)
Mailing address: P. O. BOX; CITY/STATE/ZIP	**Type of Claim** **Number** • Indemnity • Denied
Manager Name:	• Medical Only _____
Telephone:	Total
Fax No:	• Indemnity with payments
E-Mail:	• Open claims (all yrs) end of 2004

COMPANY NAME	**CHECK ONE:**
STREET ADDRESS	_____ Insurance Company
CITY/STATE/ZIP	_____ Self-insured employer (private or public including joint powers authority)
Mailing address: (P. O. BOX; CITY/STATE/ZIP)	**Type of Claim** **Number** • Indemnity • Denied
Manager Name:	• Medical Only _____
Telephone:	Total
Fax No:	• Indemnity with payments
E-Mail:	• Open claims (all yrs) end of 2004

Complete and attach additional sheets if necessary. The sum of the totals for claims of all entities reported for Part 2 must equal the total of claims reported for Part 1.